IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 17, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, Idaho 83687

Provider #13G001

Dear Ms. Broetje:

On **October 9, 2008**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003793

Allegation: An individual is choking another individual without staff intervention.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

An individual's record documented he had a history of assaulting and choking other individuals. Interviews with staff revealed the individual targeted a particular peer and the peer was afraid of the individual.

The individual's records documented he had assaulted or attempted to assault a peer as follows:
9/7/08: Grabbed peer by jaw.
9/8/08: Grabbed peer by jaw and pinched.
9/9/08: Grabbed peer's jaw and squeezed.
9/11/08: Squeezed peer's face.
9/22/08: Attempted to grab peer by throat.
9/24/08: Attempt to assault peer.

There was no documentation of the individual choking other individuals during the months of May 2008 through September 2008.

Additionally, staff interviewed stated they never witnessed the individual choke a peer and they did not believe other individuals on the unit were afraid of him.

The individual's treatment team met, on 9/22/08, to discuss the individual targeting a peer. A decision was made to move the peer to a different day treatment program. The team also met on 9/24/08 and a decision was made to move the peer to a different living area.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Michael A Case, LSW

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 21, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **October 9, 2008**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003797

Allegation #1: The individuals' 1:1 staffing levels are not effective as individuals have ingested non-edible items and cut themselves.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

The facility's Significant Event Reports (SERs), Minor Incident Reports, and Investigations were reviewed and documented the following:

An individual required 1:1 staffing for severe self injurious behaviors that included obtaining items and cutting her hands, wrists and arms. The individual's Intervention Plan stated she was to have 1:1 staff in arms length with visual observation of her hands at all times and shifts.

An Investigation, dated 9/23/08, documented the individual was able to obtain and hide a safety razor. While in the bathroom, the individual cut both hands, wrists and arms. The staff who was the individual's 1:1 staff was sitting on the individuals bed.

The door to the bathroom was partially closed and the staff did not have visual contact with the individual's hands.

An individual known for severe self abusive behavior was able to cut her hands, wrists and arms due to lack of sufficient supervision by her 1:1 staff. However, the facility investigated the incident, terminated the employment of the staff providing 1:1 supervision during the time of injury, and re-trained all other staff regarding 1:1 supervision for the individual.

A second individual required 1:1 staff for PICA (ingestion of non-edible items). The individual's Intervention Plan stated he was to have 1:1 staff in arms length with visual observation of his hands at all times except when he was in his room. While in his room he was to have "Close Proximity Supervision," defined as staff maintaining a distance of no greater than approximately twenty feet and be able to intervene within ten seconds.

The individual's Behavioral Reporting Forms (BRFs) for 9/08 documented he was able to obtain and ingest dangerous items, with some incidents being observed and reported by staff and other incidents being reported by the individual as follows:

- On 9/17/08: The individual swallowed an object that "looked like an inch and a half long piece of glass or plastic" and was taken to a local hospital emergency room.

- On 9/22/08: The individual self reported that he had swallowed a fishing hook and was taken to a local emergency room.

- On 9/25/08: The individual self reported he had swallowed a metal object (3-5 centimeters) and was taken to a local emergency room.

- On 9/27/08: "After 10 min (minutes) of isolating {the individual} showed staff a watch pin and placed it in his mouth."

An individual was able to obtain and ingest dangerous items while on 1:1 staffing. However, the individual's treatment team met and discussed his maladaptive behavior of Pica and ability to obtain items while on 1:1 supervision. As a result, observations by professional staff to identify additional issues, as well as additional staff training, was implemented.

Therefore, the allegation was substantiated. However, the facility was addressing all issues and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: An individual is harassing other individuals on a living unit.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

Ten individuals were selected for review. Observations were conducted at on-campus day programs and on the living units throughout the survey. During the observations, one individual was noted to call her peers names and threaten physical violence towards them. Staff were noted to separate the individual from her peers and attempt to redirect her peers away from the individual. During one observation, the facility's Licensed Counselor was noted to ask the individual (who was verbally assaultive) to go with her (the counselor) to her office for a counseling session.

No less than 3 staff were interviewed and stated one individual frequently threatened her peers but did not target a specific individual. Staff stated if individuals were abusive to their peers, staff would separate them. Staff stated any client to client verbal or physical assaults would be noted on the Behavior Reporting Forms (BRFs).

Behavior Reporting Forms, Significant Event Reports, staff communication logs, a Third Quarter Tracking Form, Investigations and Minor Event Forms from 9/1/08 - 10/7/08 were reviewed. The documents did include incidents of an individual being verbally assaultive toward her peers. Patterns of the individual targeting a specific individual were not noted.

No less than 4 individuals were interviewed, on 10/7/08 between 5:40 - 6:15 p.m., and all individuals stated one individual frequently threatened them and the staff would intervene. The individuals stated they were tired of this individual calling them offensive names. The Clinician and Qualified Mental Retardation Professional (QMRP) were interviewed and stated one individual frequently threatened staff and her peers, but did not target any specific individual. The QMRP stated if the individual was being verbally abusive, staff would encourage her peers to go to the patio or to the other side of the unit. The Clinician stated the individual had recently been admitted to the facility and data was being collected for the individual's maladaptive behaviors. The Clinician stated data for threats and verbal abuse would be used to develop an objective to decrease the individual's maladaptive behaviors.

Therefore, the allegation was substantiated. However, due to staff intervention during incidents of verbal assaults, in addition to the assessment of the behavior and development of programs, no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #3: Significant numbers of medication errors are occuring which have the potential to negatively impact the individuals residing at the facility.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

A total of eight individuals were observed during medication administration. The medications individuals' received were compared with their Medication Administration Records (MARs) and their Physician's Orders with no errors noted.

Additionally, nine Medication Incident Report Forms (MIRFs) for the month of September were reviewed and documented 46 medication errors. Five of the MIRFs reviewed included Plans of Correction and all other MIRFs were in the process of being investigated.

The Director of Nursing (DON) stated during an interview, on 9/30/08 from 9:40 - 10:23 a.m., if a unit was noted to have medication administration errors, the Licensed Practical Nurse (LPN) or the Registered Nurse (RN) would observe the staff administer medication to identify any concerns. If concerns were identified, the nurse would provide training during the monthly meeting for the unit. The DON stated each medication error was written on a MIRF. The medication error was investigated and a plan of correction was written to address the reason for the error and to prevent the medication error from reoccurring.

The DON stated from the investigation, the RN determined if an error was a class A (high level of significance) or class B (low level of significance). The DON stated most of the medication errors were errors of omission, determined as a class B, and did not have any negative health outcomes for the individuals. She stated all medication errors are noted on the 24 hour Campus Nurse Report, and after being reviewed by the DON, the report was sent to the Qualified Mental Retardation Professionals (QMRPs), the Physicians, and the RNs. The DON stated Pharmacists and Nursing staff met monthly to discuss all MIRFs and follow up on the medication errors.

The DON was asked about a MIRF regarding an individual who continued to receive medication after the physician had discontinued it. The DON stated it was the LPN's responsibility to remove the medication from the individual's current medication supply and document on the MAR that the medication had been discontinued. The DON stated the MIRF for the aforementioned incident was being investigated by the RN.

Pharmacy/Nursing Team Meeting minutes for July, August and October (the October meeting was a late review for September) were reviewed. All of the meeting minutes documented MIRFs were reviewed and plans were in progress to address the medication errors.

The Pharmacy/Nursing Team Meeting minutes for July 30, 2008 also documented "Low number of MIRF in comparison to the number of dosages given overall, (approximately 30,000 doses per month). 10.7 is the average number of MIRF's per month. This gives the facility a 99.9943% correct rate." Staff meeting minutes for two units identified as having medication errors were reviewed and were noted to have the RN provide an in-service to staff regarding medication error concerns.

Medication errors have occurred. However, the facility investigated and addressed those errors. Therefore, due to a lack of sufficient evidence, the allegation was not substantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A new staff was left alone with an aggressive individual and the individual assaulted the new staff.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

The facility's Significant Event Reports, Minor Incident Reports, and Investigations from 8/29/08 - 10/6/08 were reviewed. There was no documentation of an individual being alone with new staff and being assaultive.

Additionally, the record of an individual known to be assaultive and requiring 1:1 staffing was reviewed. The individual's Behavior Report Forms documented no instances regarding the individual being left with a new staff who was assaulted. Additionally, the individual's medical record was reviewed and documented no instances that would support the allegation. The unit's communication log was reviewed and found to contain no documentation that would support the allegation.

No less than 5 direct care staff were interviewed on 9/30/08 from 2:50 - 3:45 p.m. No staff were aware of an incident where an individual was left with a new staff and became assaultive. The QMRP (Qualified Mental Retardation Professional) was interviewed and was not aware of an instance where an individual was left with a new staff and became assaultive.

The facility's Human Resource staff was interviewed on 9/30/08 at 4:00 p.m. The staff stated she tracks all injuries to staff from individuals and was not able to provide information that would support the allegation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The facility does not have adequate nursing staff.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, the nursing as worked schedule was reviewed, individuals' nursing notes were reviewed, observations, and interviews with facility staff were completed with the following results:

The Director of Nursing (DON) was interviewed on 9/30/08 at 9:15 a.m., and stated for the day and afternoon shift, a minimum of 3 Licensed Practical Nurses (LPNs) were needed. The DON stated for the night shift, the facility required a minimum of 2 nurses. The LPNs' September as-worked schedule was reviewed and documented all shifts had met or exceeded the minimum number of nurses required for each shift. Direct care staff were interviewed and stated a nurse was always available when needed for questions or health care concerns of individuals.

During observations, nurses were noted to be on the units providing care to individuals or documenting information in the individuals' medical records. Nursing notes for individuals were reviewed and contained current health information for the individuals reviewed. All health concerns noted for individuals were being addressed by the nursing staff.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 21, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **October 9, 2008**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003802

Allegation #1: Individuals are being injured during restraints.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, a review of the facility's Significant Event Reports (SERs), Minor Event Reports, and Investigations from 8/29/08 - 10/6/08, along with individuals' records and interviews with facility staff, were completed with the following results:

Three individuals were identified as receiving significant injury during restraint, two of which required medical treatment at an emergency department, as follows:

- An individual received a laceration to the head during a restraint that required sutures at the emergency department of a local hospital. The Qualified Mental Retardation Professional (QMRP) documented he retrained the staff involved in the restraint regarding proper implementation and preventative actions. He also stated he retrained all staff regarding the individual's Behavior Support Plan (BSP) including precursors to maladaptive behaviors that could result in restraints, identified the precursor to the restraint and implemented corrective action to prevent re-occurrence of the maladaptive behavior that resulted in the restraint.

The QMRP also worked with direct care staff to identify and implement other techniques that might be used to redirect the individual during maladaptive behaviors before restraint became necessary.

- A second individual received a laceration to the mouth believed to be self inflicted by biting, during a restraint. The injury required sutures at the emergency department of a local hospital. The QMRP was interviewed during the complaint investigation and stated he retrained the staff involved in the restraint. He also stated he re-evaluated the individual's need for restraint and the individual's BSP in regards to what type of restraint and when to apply the restraint. The individual's medical needs in relation to restraint was also re-evaluated.

- A third individual received bruises in the shape of snaps from his shirt during a restraint. The individual did not require medical treatment from the injury and the incident was investigated by the facility.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: Guardians are not notified of individuals' significant incidents, injuries, and illnesses per the guardians' requests.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of the facility's Significant Event Reports (SERs), Minor Incident Reports, Investigations, and individuals' records were completed with the following results:

The facility's Significant Event Reports (SERs), Minor Incident Reports, and Investigations from 8/29/08 - 10/6/08 were reviewed. During that time, no failure to notify guardians of significant or requested events was identified.

An individual's record was reviewed and contained documentation that her guardian wanted to be notified via e-mail for all PRNs (as needed medications) received for maladaptive behaviors, and to be notified for all self harm behaviors.

The individual's nursing notes and Physician's Order and Progress Notes were reviewed. The record contained documentation of guardian notification for each PRN behavioral medication, illness, and significant medical change. Notification to the guardian of the individual's self harm behaviors was also documented.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals are not receiving appropriate medical care and staffing to meet their medical needs.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

The facility's Significant Event Reports (SERs), Minor Incident Reports, and Investigations from 8/29/08 - 10/6/08 were reviewed. Additionally, no less than 9 individuals' medical records were reviewed including, but not limited to, OPFR (nursing) notes and Physician's Orders and Progress Notes. The documentation included information related to individuals' medical conditions, injuries, illnesses, treatment, follow-up, and progress. There was no documentation indicating individuals were not receiving appropriate medical care.

The Director of Nursing (DON) was interviewed on 9/30/08 at 9:15 a.m., and stated for the day and afternoon shift, a minimum of 3 Licensed Practical Nurses (LPNs) were needed. The DON stated for the night shift, the facility required a minimum of 2 nurses. The September as worked schedule for the LPNs was reviewed and documented all shifts had met or exceeded the minimum number of nurses required for each shift. Additionally, direct care staff stated a nurse was always available when needed for questions or health care concerns of individuals.

During observations throughout the investigation, nurses were noted to be on the units providing care to individuals or documenting information in the individuals' medical records.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Investigations into individuals' significant injuries are not sufficient.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

The facility's Significant Event Reports (SERs), Minor Incident Reports, and Investigations from 8/29/08 - 10/6/08 were reviewed and showed the following:

An Investigation, dated 9/11/08 documented an individual received injuries during a restraint which consisted of "7 metal snap imprints on his chest." The incident was investigated nine days after occurrence, at which time the injuries sustained during the restraint were still visible.

The investigation did not include an assessment of the restraint used. Additionally, the investigation did not include corrective action pertaining to the restraint, such as retraining the staff involved in the restraint.

When asked during an interview on 10/7/08 from 9:40 - 10:20 a.m., the Qualified Mental Retardation Professional (QMRP) stated he did not see the restraint and did not know the outcome of the investigation into the injuries.

The QMRP stated he was not sure how the individual received the injuries.

The facility failed to ensure the investigation contained thorough, comprehensive information and included appropriate corrective action.

An SER, dated 8/7/08, documented an individual had an unknown injury to her right foot. The facility completed an investigation for medical neglect regarding the incident. However, the investigation did not include information regarding the origin of the injury.

Attached to the SER was a form, titled Investigation Of Injury of Unknown Origin. The form included sections to be completed by nursing staff, charge staff, and staff interviews. The documentation showed six swing shift staff were asked about the injury. However, the form did not include information that staff from other shifts had been interviewed regarding the origins of the injury.

The investigation into the individual's broken foot did not contain detailed and comprehensive documentation as to the origin of the injury.

Therefore, the allegation was substantiated. The facility was cited at W154 and W157 during a complaint survey, dated 8/29/08, and was still in the correction period. Therefore, no deficiency was cited.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #5: Medications were left unlocked, as a result an individual ingested unprescribed medications.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records and interviews with facility staff were completed with the following results:

An individual's nursing notes documented, on 6/1/08, time not indicated, "at beginning of shift {name of individual} made her way unsupervised into Med. {sic} room and removed 100 mg Thorazine (2 tabs) {an anti-psychotic drug} and 9 mg melatonin (3 Tabs) {an herbal supplement} from med cart." The nursing notes documented monitoring the individual for adverse reactions.

A Significant Event Report (SER), dated 6/1/08, documented the door to the medication room was not closed completely following a medication count at shift change and staff did not lock the medication cart. An individual entered the medication room, removed her own medication blister packs and punched out 2 Thorazine tablets and 3 melatonin tablets.

Both Thorazine and melatonin were PRN (as needed) medications. Staff witnessed the event and asked the individual for the medications. The individual admitted to punching pills from the blister packs, but denied taking the medications. However, staff were only able to find one of the pills, a Thorazine tablet.

During an interview on 10/8/08 from 3:05 - 3:20 p.m., the Registered Nurse (RN) stated all staff were retrained on ensuring the medication room door was shut properly and locking the medication cart as a result of the incident on 6/1/08.

During an interview on 10/8/08 from 3:25 - 3:40 p.m., the QMRP (Qualified Mental Retardation Professional) stated the situation on 6/1/08 was investigated and showed the medication room door was not closing completely. The QMRP confirmed staff were retrained with regards to ensuring the door was shut and locked, and ensuring the medication cart was locked. Additionally, the staff that was responsible for the medications at the time was retrained.

An individual did obtain medications as a result of staff failing to lock the medication cart and medication room. Therefore, the allegation was substantiated. However, no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #6: An individual has developed pressure sores.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, and interviews with facility staff were completed with the following results:

The Physician's Orders and Progress Notes of an individual that was on non-weight bearing status documented, on 9/29/08, "inner thigh (and) bottom sores." A second Physicians's Orders and Progress Notes, dated 9/30/08, documented an "irregularly demarcated lesion" to the individual's right buttock.

During an interview on 10/7/08 from 10:40 - 11:55 a.m., the Director of Nursing (DON) stated the individual's wounds were the result of scratching and were not pressure sores. The DON stated the wounds were in fleshy tissue between the individual's buttocks and not on a bony area of the body.

The DON stated the wounds appeared to be from the individual scratching herself.

During an interview on 10/7/08 at 11:55 a.m., a Physician, who examined the individual, stated the individual's wounds appeared to be from scratching herself. The Physician stated the wounds were cultured and came back negative for viral infection and appeared to be related to a yeast infection.

The Physician stated the wounds were treated with an anti-fungal cream.

No other documentation regarding potential pressure wounds was found. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated. No deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Individuals' bedrooms are unsanitary and unsafe.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

An individual's bedroom was observed on 10/8/08, and was noted to have dirty clothing piled on the floor by the bedroom door. The same individual's bedroom had been observed on 10/6/08 and 10/7/08 and did not have dirty clothing on the floor.

Two direct care staff and a unit supervisor were interviewed. All staff stated the individual's room had been very cluttered and included dirty food dishes, candy wrappers, clothing, trash and debris about two months ago. However, staff now go through her room with her on a weekly basis to ensure it was clean, and prompt her on a daily basis to clean her room. All staff stated the individual's room will sometimes have dirty clothing on the floor, but has not risen to the level of being a health hazard.

Additionally, the second individual's QMRP was interviewed, on 10/7/08 from 4:05 - 4:35 p.m., and stated the second individual was involved in writing her own program for room cleaning in an effort to invest her in her own treatment.

The individual's room was unsanitary but had been cleaned, and the facility was taking steps to assist the individual in maintaining her room in a sanitary manner.

On 10/2/08, the bedroom of a second individual, known to engage in self abusive behaviors, was observed to contain multiple items (staples, paper clips, glass etc.) historically used by the individual to harm herself.

Additionally, the bedroom contained dirty clothing, plastic boxes containing dirt and rocks, scraps of paper and magazine pages piled throughout the room, candy wrappers, plastic soda bottles, and other trash and debris covering the floor.

The individual's Behavior Support Plan (BSP) stated room searches were to be completed on a weekly basis or as needed to remove items the individuals could use to harm herself.

However, the documentation showed a room search had not been completed in approximately 3 months.

No less than 5 direct care staff were interviewed about the individual's room searches. All staff stated the items found should not be present in the individual's room. All staff stated they were not sure who completed the room searches.

When asked about the individual's bedroom, on 10/2/08 from 12:25 - 1:00 p.m., the QMRP (Qualified Mental Retardation Professional) stated the items found in the individual's bedroom should have been removed. The QMRP stated room searches had not been completed as required by the individual's BSP.

The facility failed to ensure the second individual's bedroom was safe from items the individual could use to harm herself.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #8: Individuals' as needed medications are being withheld.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records and interviews with facility staff were completed with the following results:

No less than 6 medication administration records were reviewed. There were no indications in the records that individuals' as-needed medications were being withheld.

The medical charts of two individuals receiving PRN (as needed) medications were reviewed. The records documented the individuals had received PRN medication. There was no indication individuals' PRN medications were being withheld.

Additionally, no less than 4 medication certified staff were interviewed. All staff stated they were unaware of any individuals as-needed medications being withheld.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: An individual is not being considered for discharge.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, and interviews with facility staff were completed with the following results:

An individual's record was reviewed. The record contained no information stating the individual was not being considered for discharge. Additionally, the Qualified Mental Retardation Professional (QMRP) was interviewed, on 10/9/08 at 9:50 a.m., and stated the individual's discharge packet was almost complete. The QMRP stated the individual's Community Risk Assessment was in process and should be completed by the following week. At that time, the packet would be "sent out" for consideration for outside placement.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #10: Documentation in the individuals' records is inadequate.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

The facility's Significant Event Reports (SERs), Minor Incident Reports, and Investigations from 8/29/08 - 10/6/08 were reviewed. Additionally, no less than 9 individuals' medical records were reviewed including, but not limited to, nursing notes and Physician's Orders and Progress Notes. The documentation included information related to individuals' medical conditions, injuries, illnesses, treatment, follow-up, and progress. There was no indication of a lack of documentation regarding the individual's medical treatment.

Additionally, individuals' behavioral data was reviewed and compared with observations conducted throughout the survey. The evidence did not support the allegation that individuals' records contained inadequate documentation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #11: Staff allow individuals to have inappropriate items.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

An individual required 1:1 staff for PICA (ingestion of non-edible items).

The individual's Intervention Plan stated he was to have 1:1 staff in arms length with visual observation of his hands at all times except when he was in his room. While in his room he was to have "Close Proximity Supervision," defined as staff maintaining a distance of no greater than approximately twenty feet and be able to intervene within ten seconds.

The individual's Behavioral Reporting Forms (BRFs) for 9/08 documented he was able to obtain and ingest dangerous items, with some incidents being observed and reported by staff and other incidents being reported by the individual as follows:

- On 9/17/08: The individual swallowed an object that "looked like an inch and a half long piece of glass or plastic" and was taken to a local hospital emergency room.

- On 9/22/08: The individual self reported that he had swallowed a fishing hook and was taken to a local emergency room.

- On 9/25/08: The individual self reported he had swallowed a metal object (3-5 centimeters) and was taken to a local emergency room.

- On 9/27/08: "After 10 min (minutes) of isolating {the individual} showed staff a watch pin and placed it in his mouth."

The facility failed to ensure an individual was prevented from obtaining items used for Pica. However, the individual's treatment team met and discussed his maladaptive behavior of Pica and ability to obtain items while on 1:1 supervision. As a result, observations by professional staff to identify additional issues, as well as additional staff training, was implemented.

On 10/2/08, the bedroom of a second individual, known to engage in self injurious behaviors, was observed to contain multiple items historically used by the individual to harm herself, including plastic spoons, broken CD covers, wire backed earrings, staples, and electrical cords to her television, VCR, fish tank, fan, and computer. Additionally, the bedroom contained dirty clothing, plastic boxes containing dirt and rocks, scraps of paper and magazine pages piled throughout the room, candy wrappers, plastic soda bottles, and other trash and debris covering the floor.

The individual's Intervention Plan stated room searches were to be completed on a weekly basis or as needed to remove items the individual could use to harm herself. However, the documentation showed a room search had not been completed in approximately 3 months.

Additionally, the individual's record documented no less than 4 surgical procedures in 2008 to remove items the individual had inserted under her skin.

No less than 5 direct care staff were interviewed about the individual's room searches. All staff stated the items found should not be present in the individual's room. All staff stated they were not sure who completed the room searches.

When asked about the individual's bedroom, on 10/2/08 from 12:25 - 1:00 p.m., the QMRP stated the items found in the individual's bedroom should have been removed. The QMRP stated room searches had not been completed as required by the individual's Intervention Plan.

During an interview with the Director of Nursing Services and the Physician, on 10/2/08 from 2:45 - 3:30 p.m., both stated the items found in the individual's room should should have been removed based on the individual's history of self injurious behaviors.

The facility failed to ensure a second individual was prevented from obtaining items known to be used during self injurious behaviors.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #12: An individual's right to retain personal possessions is being violated.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

Individuals' bedrooms were observed on 10/2/08, 10/6/08, 10/7/08, and 10/8/08. During those observations, individuals' rooms were noted to contain personal items and clothing. There was no indication individuals' personal items were being withheld.

Additionally, other areas were observed including, but not limited to, common areas, staff areas, break rooms, medication administration areas, and offices. At no time were individuals' personal items observed to be stored or maintained in those areas.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #13: The facility failed to actively pursue guardianship for an individual.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. Individuals' record were reviewed with the following results:

The record of an individual, soon to turn the age of 18, was reviewed.

Contact information indicated both of the individual's parents were being contacted for consents and notifications as the individual's guardians.

The QMRP (Qualified Mental Retardation Professional) provided a document, titled "QMRP Additionally PCP (Person Centered Plan) Narrative", which stated the QMRP and Social Worker had met with the Facility Administrator on 9/3/08 regarding the individual's guardian. Additionally, the document stated the facility was working with the facility's legal counsel to determine who was to pursue guardianship for the individual.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #14: An individual's PRN (as needed) medications are interfering with activities of daily living.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of individuals' records, and observations were completed with the following results:

An individual's record was reviewed and documented she received Thorazine (an antipsychotic drug) 50 mg PRN (as needed) as a "chemical restraint." A nursing note, dated 9/3/08 at 10:25 a.m., stated the individual indicated Thorazine made her sleepy and requested a different PRN. Ativan (an anxiolytic drug) 0.5 mg was used instead. The record further documented the individual's PRN Thorazine would be tried at 25 mg to see if concern with sedation was resolved.

A Psychiatry Clinic note, dated 9/12/08, stated the facility had "reduced the dose of her chemical restraint to Thorazine 25 mg which seems to be working pretty well for her. She was a bit over-sedated apparently on the 50 mg." Additionally, no documentation of over-sedation was noted following the decrease in the drug dose.

The individual was observed multiple times throughout the survey. The individual was noted to be alert and able to respond appropriately to questions. The individual was interviewed regarding her care and did not express any concerns regarding being over-sedated.

Therefore, the allegation was substantiated. However, the facility had identified and corrected the issue and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 17, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, Idaho 83687

Provider #13G001

Dear Ms. Broetje:

On **October 9, 2008**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003806

Allegation: The facility's grievance policy is not adequate.

Findings: An unannounced on-site complaint investigation was conducted from 9/29/08 through 10/9/08. During that time, review of the facility's operating policy and procedures and interviews with facility staff were completed with the following results:

The facility's Client Complaint and Grievance policy, dated 4/22/08, was reviewed. The policy outlined steps to be taken by the client, legal guardian, or personal representative to file a complaint or grievance. Additionally, the policy outlined steps to be taken by the facility to resolve any grievance. The steps outlined by the policy were as follows:

- The client, guardian, and/or personal representative complete the Client Complaint and Grievance form.

- The Client Complaint and Grievance form is forwarded to the Social Worker for resolution. The Social Worker assembles a Review Team. The Review Team consists of a minimum of a representative from the facility's Performance Improvement Department and two treatment team members. The Review Team reviews the information and proposes a resolution to the client within 5 working days. The resolution and client's degree of satisfaction with the resolution is documented on the form.

- If the issue is not resolved and/or the client is not satisfied with the resolution, the client may request a review by the Client Grievance Committee. The committee is to consist of three staff chosen by the Administrative Director. The Committee reviews the original grievance and proposed resolution, then meets with the client to discuss their concerns. The committee is to propose alternative solutions to the client within 5 working days of receipt of the unresolved grievance.

- If the Client Grievance Committee's resolution is unsatisfactory to the client, the client may request an Independent Review. The policy stated "This review may be conducted by the client's choice of persons or groups, such as a hearing officer, lawyer, or private advocacy group."

The policy did not clearly define "persons or groups." Therefore, it was not clear if those conducting the Independent Review were required to be chosen from a professional category (i.e., "hearing officer, lawyer, or private advocacy group") or could be chosen from non-professional sources as well (i.e., family, friends, parent organizations, church groups, etc.). Additionally, the Independent Review phase of the policy did not specify time-lines in which the process was to be completed.

During an interview on 10/7/08 from 1:33 - 2:25 p.m., the Administrator stated the facility's Client Complaint and Grievance policy was currently being reviewed. The Administrator stated the term "group" in the Independent Review phase of the policy was confusing. The Administrator stated no grievances at the facility had progressed to the Independent Review process until recently, which was how the confusion in the policy had been discovered.

The Administrator showed the survey team a draft copy of the policy with revisions. The drafted copy of the policy was revised to include timelines for the Independent Review process.

The facility's Client Complaint and Grievance policy was inadequate in that the instructions for Independent Review were unclear and did not contain time lines. Therefore, the allegation is substantiated. However, the facility was cited at W125 during a complaint survey, dated 8/12/08, and was still in the correction period. Therefore, no deficiency was cited.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

October 21, 2008

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School And Hospital, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Complaint Survey of Idaho State School And Hospital, which was conducted on October 9, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 2, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by November 2, 2008. If a request for informal dispute resolution is received after November 2, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

Susan Broetje – Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho State Developmental Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@dhw.idaho.gov

November 3, 2008

Debbie Ransom, R.N., R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Enclosed you will find the Plan of Correction for W104, W159, and W193 which were cited during the complaint survey on October 9, 2008.

If you have any questions, please call me at 442-2812. Thank you.

Sincerely,

SBroetje

Susan Broetje
Administrative Director
Idaho State School & Hospital

lv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Leader Stanley Rennaux, RN, BSN, MEd Sherri Case, LSW, QMRP Matthew Hauser, QMRP Jim Troutfetter, QMRP Common abbreviations used in this report are: BRF - Behavioral Reporting Form DON - Director of Nursing PCP - Person Centered Plan QMRP - Qualified Mental Retardation Professional SER - Significant Event Report SIB - Self Injurious Behavior	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for individuals residing at the facility. This failure negatively impacted 2 of 13 individuals (Individuals #12, and #13) reviewed, and had the potential to negatively impact all individuals residing at the facility. Failure of the governing body to ensure these requirements were met resulted in individuals not being adequately supervised and protected from self harm, and allegations of abuse not being	W 104	see attached RECEIVED NOV 04 2008 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje ADMIN DIRECTOR 11/3/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 investigated. The findings include: 1. The facility's Client Significant Event Reporting policy, dated 10/1/08, stated the purpose of the the policy was to "outline steps to document and address significant events that have either resulted in harm or pose a significant risk of harm to the clients who reside at the [name of facility]...The policy also provides a system for developing procedures to reduce these types of incidents as well as a system of aggressive team action and administrative review of significant events." The Definitions section of the policy provided definitions of significant events which included the following: - Significant Injury: "A bodily injury which either requires medical treatment by a nurse, physician, or outside medical care provider...Caused by Self: A significant intentional self-inflicted injury." - Pica Requiring Medical Intervention: "Ingestion of cigarettes, cigarette butts, batteries, glass, metal or plastic items with sharp edges/points, or ingestion of a chemical or poison that requires treatment beyond monitoring after calling the Poison Control Center." Individual #12's 9/2/08 PCP stated she was an 18 year old female whose diagnoses included mild mental retardation, oppositional defiant disorder, major depression, and possible borderline personality disorder. Individual #12's PCP stated she "has a history of wounding self with a staple. She clipped [sic] herself with staples in her hands, wrist, and arms. She was seen multiple times by physicians and surgeons for removal of staples...ALERT:	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 2 [Individual #12] currently has staples under skin in left forearm and right upper arm. She had a consultation with [Physician's Name], a general surgeon, on 7/21/08 and he recommended fo [sic] no surgical intervention unless it gets infected." Individual #12's PCP listed the following invasive medical procedures to remove staples: - 9/5/07: A campus physician removed a staple embedded in Individual #12's right wrist. - 12/21/07: A campus physician removed staples from Individual #12's left hand. - 2/5/08: Staples which were located deep in Individual #12's wrist, forearm, and back of arm were removed. Individual #12's BRFs included SIB, defined as "Intentionally causing harm to her own body by cutting and scratching that draws blood, bruising, picking at scabs to draw blood, slapping, hitting, pulling own hair, head banging." The BRF did not include insertion of metal under the skin in the definition of SIB. When asked during an interview on 10/7/08 from 9:40 - 10:20 a.m., the QMRP stated Individual #12's incidents of inserting metal objects under her skin were not observed. The QMRP stated Individual #12 would self report after she had inserted the object and the wound had healed. The QMRP stated Individual #12's behavior of inserting would be considered SIB but was not specifically spelled out in her Intervention Plan. Individual #12's maladaptive behavior of inserting objects under the skin, which then required invasive medical intervention to remove the objects, met the definition of self inflicted significant injury per the facility's policy. However,	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 3 because the events were not witnessed by staff but were self reported by Individual #12, the incidents were not documented on an SER. Without clear documentation of Individual #12's maladaptive behavior of inserting objects on an SER, action steps outlined by the policy could not be implemented, including completion of the Team Review process by the QMRP, entering of information into the database by the Performance Improvement Department, reviewing of plans and documenting concerns by the Performance Improvement Department, monitoring of trends by the QMRP, Program Director and Administrative Director, and ensuring implementation of changes in the facility practices as needed by the Administrative Director. The facility failed to ensure the Client Significant Event Reporting policy was implemented and monitored for Individual #12. 2. The facility's Abuse Prevention policy, dated 4/11/08, stated if abuse or neglect was witnessed or suspected by any staff member, they were to "Call the Switchboard and announce that you need to report an allegation of abuse or neglect." A BRF, dated 8/31/08, stated Individual #13 "accused staff of raping him and punching him in his face." A Communication Log entry, dated 9/23/08, stated Individual #13 "was making aliegtion [sic] that [name of staff] was abusing client." During an interview on 10/7/08 from 3:20 - 4:00 p.m., the facility's Lead Investigator stated he was not aware of the allegations made by Individual	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 4 #13 on 8/31/08 or 9/23/08 and the allegations had not been investigated. During an interview on 10/8/08 from 1:55 - 2:20 p.m., the QMRP stated he was not aware of the allegations made by Individual #13 on 8/31/08 or 9/23/08. The QMRP stated he reviewed the Communication Log and would have reviewed the BRF because it was attached to an SER. The QMRP stated the allegations should have been reported and stated "I missed it." During an interview on 10/8/08 from 4:35 - 5:10 p.m., the Administrative Director stated she was not aware of the allegations but they should have been reported for investigation. The facility failed to ensure the Abuse Prevention policy was implemented for Individual #13. 3. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' services were sufficiently coordinated and monitored by the QMRP. The facility was previously cited at W159 during a follow up survey dated 11/8/02, a complaint investigation dated 4/24/03, a recertification survey dated 8/1/03, a follow up survey dated 5/5/04, a follow up survey dated 8/26/04, a recertification survey dated 8/27/04, a recertification survey dated 3/29/05, a recertification survey dated 6/19/06, a follow up survey dated 8/28/06, a complaint investigation dated 9/20/06, a recertification survey dated 4/18/07, a recertification survey dated 3/17/08, and a complaint survey dated 8/29/08.	W 104		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159	see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 5 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure the QMRP provided sufficient integration, monitoring, and coordination of the status of 1 of 13 individuals (Individual #12) reviewed. That failure resulted in individuals not receiving the services and supports required to meet their needs. The findings include: 1. Individual #12's 9/2/08 PCP stated she was an 18 year old female whose diagnoses included mild mental retardation, oppositional defiant disorder, major depression, and possible borderline personality disorder. a. Individual #12's PCP stated she "has a history of wounding self with a staple. She clipped [sic] herself with staples in her hands, wrist, and arms. She was seen multiple times by physicians and surgeons for removal of staples...ALERT: [Individual #12] currently has staples under skin in left forearm and right upper arm. She had a consultation with [Physician's Name], a general surgeon, on 7/21/08 and he recommended fo [sic] no surgical intervention unless it gets infected." Individual #12's PCP listed the following medical procedures to remove staples: - 9/5/07: A campus physician removed a staple embedded in Individual #12's right wrist. - 12/21/07: A campus physician removed staples from Individual #12's left hand.	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 6 - 2/5/08: Staples which were located deep in Individual #12's wrist, forearm, and back of arm were removed. During an interview on 10/2/08 from 2:45 - 3:30 p.m., the DON and Physician both stated Individual #12's maladaptive behavior of inserting objects under her skin presented risks of infection, as well as the risks involved with removing the objects as the procedures were invasive. Individual #12's Behavior Reporting Form defined SIB as "Intentionally causing harm to her own body by cutting and scratching that draws blood, bruising, picking at scabs to draw blood, slapping, hitting, pulling own hair, head banging." The definition did not include inserting objects, such as staples, under her skin. No additional information was included on the BRF regarding the behavior of inserting objects under her skin. Individual #12's BRFs, from 8/29/08 - 9/30/08 were reviewed. Th BRFs documented incidents of SIB but did not include incidents of inserting staples under her skin. When asked during an interview on 10/7/08 from 9:40 - 10:20 a.m., the QMRP stated Individual #12's incidents of inserting metal objects under her skin were not observed. The QMRP stated Individual #12 would self report after she had inserted the object and the wound had healed. The QMRP stated Individual #12's behavior of inserting would be considered SIB but was not specifically spelled out in the Intervention Plan. Without including a clear definition of Individual #12's maladaptive behavior of inserting metal	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 7 objects under her skin, the QMRP would not be able to ensure the behavior was monitored and integrated into her plan. b. Individual #12's Intervention Plan, revised 2/27/08, stated "[Individual #12] is inclined to seek out opportunities to find items to use for self-injurious behaviors." The Intervention Plan included a section titled "Random Room Searches/removal of items" which stated room searches were to be completed "at least 1 time per week," but could be completed at any time. The Intervention Plan stated room searches would be done to ensure Individual #12's safety due to a history of cutting and scratching herself with dangerous items. Individual #12's Intervention Plan stated "Examples of items that could be dangerous include pop can caps, cigarette lighters, staples, paper clips, pens, pencils, cords of any kind, cleaning fluids (she has ingested them), pills (she has stock-pilled them) etc. [sic]." Individual #12's Intervention Plan also stated "Remove any item that [Individual #12] may be able to cut, insert under her skin, or scratch with. Keep in mind that [Individual #12] has a history of using a variety of objects. The team must take steps to prevent [Individual #12] from hurting herself." Individual #12's record documented a room search had been completed on 7/22/08, at which time numerous ear rings, an ear ring holder, grooming supplies, magazines, a CD case, a calendar, scrap books, and a note book had been removed. The record contained no additional documentation of room searches being	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 8 completed. An observation of Individual #12's bedroom was completed on 10/2/08 at 8:40 a.m. During that time, items found that could be potentially dangerous to Individual #12 included, but were not limited to, the following: - An electric fan was beside the bed and was running. The back of the fan was missing exposing the electrical workings. The cord of the fan was exposed. - No less than 10 plastic spoons were found throughout the bedroom and bathroom. - No fewer than 5 hanging calenders contained staples in their spines. - No fewer than 20 pens and pencils were found, most with rigid wires or plastic objects taped to the tops. - No fewer than 20 pairs of earrings with wire hoops were found. - A plastic CD case was broken and the insert contained staples. - A vocational schedule from the facility contained a staple holding the pages together. - A push-pin was inserted into a wooden frame. - A television, VCR, fish tank, and computer were present, all of which had exposed cords. - Numerous metal pop tabs were found under the mattress. - A piece of curled wire and metal pop tabs were found in the closet. A direct care staff, who was present at the time of the observation, stated the items found in Individual #12's bedroom should have been removed. During an interview on 10/2/08 from 12:25 - 1:00 p.m., the QMRP stated Individual #12's room	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 9 should not have contained the items noted by the survey team. The QMRP stated he was not aware of when the last room search was done, and was not sure who scheduled the room searches. The QMRP stated he believed the room searches should be turned into the Clinician. When asked how Individual #12's maladaptive behavior of inserting objects under her skin was monitored, the QMRP stated they "basically" attempt to keep staples away from her. During an interview on 10/2/08 from 1:10 - 1:35 p.m., the Clinician stated all of the glass Individual #12 had obtained in 9/08 was from a broken window. The Clinician stated she became Individual #12's Clinician in 7/08 and was responsible for Individual #12's Intervention Plan. The Clinician stated room searches were to be completed once weekly, but was not aware of when the last room search had been completed or what items Individual #12 currently had in her room. Without room searches being completed and monitored, the QMRP would not be able to ensure Individual #12's environment was maintained in a safe manner. Additionally, without a system to identify and track Individual #12's behavior of inserting, the QMRP would not be able to ensure accurate assessments were completed on which to base intervention strategies. The QMRP failed to ensure Individual #12's treatment program was sufficiently coordinated, monitored, and implemented in order to provide a safe environment and ensure implementation of programming sufficient to meet her behavioral needs.	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 10 2. Refer to W193 as it relates to the QMRP's failure to ensure staff received sufficient training to implement individuals' Intervention Plans.	W 159		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure staff demonstrated the skills and competencies to administer interventions for 1 of 10 individuals (Individual #12) whose behavioral interventions were reviewed. This resulted in staff failing to provide sufficient behavioral interventions to ensure individuals did not engage in self harming maladaptive behaviors. The findings include: 1. Individual #12's 9/2/08 PCP stated she was an 18 year old female whose diagnoses included mild mental retardation, oppositional defiant disorder, major depression, and possible borderline personality disorder. Individual #12's PCP stated she "has a history of wounding self with a staple. She clipped [sic] herself with staples in her hands, wrist, and arms. She was seen multiple times by physicians and surgeons for removal of staples...ALERT: [Individual #12] currently has staples under skin in left forearm and right upper arm. She had a consultation with [Physician's Name], a general surgeon, on 7/21/08 and he recommended fo [sic] no surgical intervention unless it gets infected."	W 193	see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 11 Individual #12's PCP listed the following invasive medical procedures to remove staples: - 9/5/07: A campus physician removed a staple embedded in Individual #12's right wrist. - 12/21/07: A campus physician removed staples from Individual #12's left hand. - 2/5/08: Staples which were located deep in Individual #12's wrist, forearm, and back of arm were removed. When asked during an interview on 10/7/08 from 9:40 - 10:20 a.m., the QMRP stated Individual #12's incidents of inserting metal objects under her skin were not observed. The QMRP stated Individual #12 would self report after she had inserted the object and the wound had healed. The QMRP stated Individual #12's behavior of inserting would be considered SIB but was not specifically spelled out in the Intervention Plan. Individual #12's Intervention Plan, revised 2/27/08, stated "[Individual #12] is inclined to seek out opportunities to find items to use for self-injurious behaviors." The Intervention Plan included a section titled "Random Room Searches/removal of items" which stated room searches were to be completed "at least 1 time per week," but could be completed at any time. The Intervention Plan stated room searches would be done to ensure Individual #12's safety due to a history of cutting and scratching herself with dangerous items. Individual #12's Intervention Plan stated "Examples of items that could be dangerous include pop can caps, cigarette lighters, staples, paper clips, pens, pencils, cords of any kind, cleaning fluids (she has ingested them), pills (she	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 12 has stock-pilled them) etc. [sic]" Individual #12's Intervention Plan also stated "Remove any item that [Individual #12] may be able to cut, insert under her skin, or scratch with. Keep in mind that [Individual #12] has a history of using a variety of objects. The team must take steps to prevent [Individual #12] from hurting herself." An observation of Individual #12's bedroom was completed on 10/2/08 at 8:40 a.m. During that time, items found that could be potentially dangerous to Individual #12 included, but were not limited to, the following: - An electric fan was beside the bed and was running. The back of the fan was missing exposing the electrical workings. The cord of the fan was exposed. - No less than 10 plastic spoons were found throughout the bedroom and bathroom. - No fewer than 5 hanging calenders contained staples in their spines. - No fewer than 20 pens and pencils were found, most with rigid wires or plastic objects taped to the tops. - No fewer than 20 pairs of earrings with wire hoops were found. - A plastic CD case was broken and the insert contained staples. - A vocational schedule from the facility contained a staple holding the pages together. - A push-pin was inserted into a wooden frame. - A television, VCR, fish tank, and computer were present, all of which had exposed cords. - Numerous pop tabs were found under the mattress. - A piece of curled wire and pop tabs were found in the closet.	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 13 A direct care staff, who was present at the time of the observation, stated the items found in Individual #12's bedroom should have been removed. Individual #12's record documented a room search had been completed on 7/22/08, at which time numerous ear rings, an ear ring holder, grooming supplies, magazines, a CD case, a calendar, scrap books, and a note book had been removed. The record contained no additional documentation of room searches being completed. When asked during an interview on 10/2/08 from 8:30 - 8:37 a.m., a Lead Worker stated she worked with Individual #12 on a daily basis. The Lead Worker stated she was not aware weekly room searches were to be completed, and had never completed a room search for Individual #12. Four additional direct care staff were interviewed regarding Individual #12's room searches on 10/2/08 between 8:30 - 9:00 a.m. All staff stated they had not participated in room searches for Individual #12. None of the staff were able to indicate who completed room searches for Individual #12, when they were to be completed, or where they were to be documented. During an interview on 10/2/08 from 12:25 - 1:00 p.m., the QMRP stated Individual #12's room should not have contained the items noted by the survey team. The QMRP stated he was not aware of when the last room search was done, and was not sure who scheduled the room searches. The QMRP stated he believed the	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 14 room searches should be turned into the Clinician. When asked how Individual #12's maladaptive behavior of inserting objects under her skin was monitored, the QMRP stated they "basically" attempt to keep staples away from her. During an interview on 10/2/08 from 1:10 - 1:35 p.m., the Clinician stated she became Individual #12's Clinician in 7/08 and was responsible for Individual #12's Intervention Plan. The Clinician stated room searches were to be completed once weekly but was not aware of when the last room search had been completed. When asked about staff training, the Clinician stated she provided the initial training to staff when an Intervention Plan was developed or revised. However, the Clinician stated she had not developed Individual #12's plan, had not revised the plan since she became the Clinician, and had not trained staff regarding room searches. The facility failed to ensure staff received sufficient training to implement Individual #12's Intervention Plan such that access to objects used to engage in SIB were limited.	W 193		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W104.	MM520	see attached response for W104	
MM620	16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W193.	MM620	see attached response for W193	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	see attached response for W159 RECEIVED NOV 04 2008 FACILITY STANDARDS	

Bureau of Facility Standards

SBoetje — Adm. Dir. — 11/3/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Plan of Correction for 10/9/08 Survey

TAG #W104

Corrective action for examples and for other individuals with the potential to be affected:
Ex. #1: In reviewing the event that resulted in the citation, it appears that nursing staff identified the potential insertion, and while appropriate nursing intervention was provided, the staff were not notified appropriately so that required documentation could be completed. The nursing and charge staff will be re-trained in the responsibility for completing documentation for all events that meet SER and Minor definitions.

Ex. #2: An investigation was completed for the affected individual. Staff will be reminded of the requirements for reporting all allegations, even ones made against themselves that they know to be false. QMRPs and Clinicians will be reminded to ensure that appropriate reporting is done if any documentation reviewed contains language that could be deemed to be an allegation of abuse, neglect, or exploitation.

Measures or a systemic change to ensure deficient practice does not recur:
The facility has identified that the current documentation system lends itself to an increased risk in error of reporting. The facility is making significant documentation and policy changes in the significant event and minor incident reporting procedures to reduce duplication of documentation and clarify expectations for all staff. The facility also identified a wording clarification that will improve the reporting in the abuse policy. Currently the policy reads that staff are to report all witnessed or suspected incidents. The wording will be revised to include all alleged incidents also.

Monitoring to ensure deficient practice does not recur:
QMRPs and Nursing staff will be required to review every Client Log and BRF generated and to sign and date that review weekly. This formal review will serve as a double check that appropriate follow-up and documentation occurs.

Date when corrective action will be completed (usually within 60 days):
Training reflected in Example 1 to be completed 11/21/08.
E-mail reminding staff of expectation for Example 2 sent 11/2/08.
Policy and reporting revisions completed and implemented by 12/15/08.

TAG #W159

Corrective action for examples:
Individual #12's interdisciplinary team met and updated and clarified her BSP and room search guidelines. Specific staff responsibilities have been outlined to ensure checks occur. A schedule as to which shift and day each search will take place has been developed.

The room search form has been individualized and signature lines added for the staff who perform the search and for the supervisor who reviews the form. The clinician will report to the QMRP the number of room searches done each month.

Other individuals with the potential to be affected and corrective action to be taken:
There will be a review by the Clinical Supervisor of all clients who require room checks to determine if they are being completed as required in their PCP. If concerns are identified, the

Clinical Supervisor will alert the applicable supervisor and QMRP to ensure that corrective action is immediately implemented. The Clinical Supervisor will provide a report to the Administrator of all reviews completed and results.

Measures or a systemic change and monitoring to ensure deficient practice does not recur:
The QMRP progress review sheet will include a review of all BSP requirements. The QMRP will request evidence of completion of all requirements and take action if requirements are not fulfilled.

The Program Director will conduct random spot checks of QMRP review sheets and compare the checklist to the BSPs to ensure that all required areas are included on the review sheets. A report will be submitted to the Administrative Director which includes the reviews completed, results, and action taken, if needed.

Date when corrective action will be completed (usually within 60 days): 12/1/08

TAG # 193

Corrective action for examples:
Individual #12's interdisciplinary team met and updated and clarified her BSP and room search guidelines and staff responsibilities have been specified. The room search form has been individualized and signature lines added for the staff who perform the search and for the supervisor who reviews. The clinician will report to the QMRP the number of room searches done each month. A schedule as to which shift and day each search will take place has been developed. Staff were trained on the expectations of the BSP.

Other individuals with the potential to be affected and corrective action to be taken:
There will be a review by the Clinical Supervisor of all clients who require room checks to determine if they are being completed as required in their PCP. If concerns are identified, the Clinical Supervisor will alert the applicable QMRP to ensure that corrective action is immediately implemented. The Clinical Supervisor will provide a report to the Administrative Director of all reviews completed and results.

Measures or a systemic change and monitoring to ensure deficient practice does not recur:
The QMRP progress review sheet will include a review of all BSP requirements. The QMRP will request evidence of completion of all requirements and take action if requirements are not fulfilled.

The Program Director will conduct random spot checks of QMRP review sheets and compare the checklist to the BSPs to ensure that all required areas are included on the review sheets. A report will be submitted to the Administrative Director which includes the reviews completed, results, and action taken, if needed.

Date when corrective action will be completed (usually within 60 days): 12/1/08